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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age

Report of the Office of the United Nations High Commissioner for Human Rights

Summary

The present technical guidance is submitted pursuant to Human Rights Council resolution 24/11. The aim of the technical guidance is to assist States and non-State actors to improve the realization of the rights of the child by providing guidance on addressing mortality and morbidity of children under 5 years of age in accordance with human rights standards. It outlines the key elements of a human rights-based approach to reducing child mortality and morbidity, provides guidance for operationalizing such an approach, and includes an illustrative example of how it can be applied.

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I. Introduction

1. The present technical guidance is submitted to the Human Rights Council pursuant to resolution 24/11 of 26 September 2013, in which it requested the Office of the United Nations High Commissioner for Human Rights, in close collaboration with the World Health Organization (WHO), to prepare concise technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age.

2. The technical guidance was prepared by OHCHR, in close collaboration with WHO and with the support of an external advisory group of human rights and child health experts. It was also informed by input received from a public consultation and responses to a note verbale circulated to States, national human rights institutions and civil society requesting relevant information. Detailed information can be found at www.ohchr.org/EN/Issues /Children/TechnicalGuidance/Pages/TechnicalGuidanceIndex.aspx.

3. In spite of significant progress in recent years, mortality and morbidity of children under 5 remain unacceptably high. In 2012, an estimated 6.6 million children died before their fifth birthday.[1] More than half of those deaths were preventable.[2] In addition, millions more children suffer illness and disability every year. Patterns of child mortality and morbidity reveal significant and persisting inequalities between and within countries, driven by poverty, social exclusion, discrimination, gender norms and neglect of basic human rights.

4. A human rights-based approach to reducing child mortality and morbidity can help draw attention to potential barriers to successfully addressing these issues, highlight the range of actors responsible for this work and provide a legal framework to strengthen public health efforts in this area. It can also facilitate the identification of populations at high risk, enable analysis of complex gaps in protection, participation and accountability, and promote the identification of comprehensive and sustainable solutions.[3] A rights-based approach can enable children and their families to live lives of dignity.

5. A broad range of international human rights treaties are relevant to child mortality and morbidity, inter alia the Convention on the Rights of the Child, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women. Furthermore, general comment No.15 of the Committee on the Rights of the Child, general comment No. 14 of the Committee on Economic, Social and Cultural Rights and general recommendation 24 of the Committee on the Elimination of Discrimination against Women are also relevant.

6. Those treaties and general comments are complemented by documents on child health published by WHO that highlight the importance of adopting a human rights-based approach to addressing child mortality and morbidity.[4] Furthermore, the centrality of a human rights-based approach to child mortality and morbidity has been recognized by a wide range of global efforts such as the United Nations Secretary-General's Global

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[1] WHO, "Children: reducing mortality", Factsheet No. 178, 2013.

[2] Ibid.

[3] A/HRC/24/60; A/HRC/22/31.

[4] F. Bustreo and others, *Women's and Children's Health: Evidence of Impact of Human Rights*, (WHO, 2013); WHO, "Every newborn: an action plan to end preventable deaths", 2014.

Strategy for Women's and Children's Health, and the Commission on Information and Accountability for Women's and Children's Health.

7. The primary purpose of the present technical guidance is to assist States and non-State actors to improve the realization of the right of the child to health and survival by providing guidance on reducing child mortality and morbidity in accordance with human rights norms, standards and principles.

8. The guidance is primarily directed towards health decision-makers and policy-makers but is also relevant to other sectors, such as the finance and education sectors, as well as to parliamentarians, the judiciary, civil society, health service providers, national human rights institutions, donor States and the private sector, as well as intergovernmental agencies.

II. Child mortality and morbidity

9. Most child mortality is due to a small number of diseases and conditions. Globally, 43 per cent of such deaths occur among babies aged 0–28 days (newborn babies)[5] and are mainly due to pre-term birth complications, birth asphyxia and trauma, and sepsis. After the first 28 days, until the age of 5 years, the majority of deaths are attributable to infectious diseases such as pneumonia (22%), diarrhoeal diseases (15%), malaria (12%) and HIV/AIDS (3%).[6] The vast majority of conditions and diseases that lead to death among children under 5 years of age are preventable and treatable through cost-effective interventions.

10. The risk factors associated with the leading causes of death in newborn babies are multiple and complex. They include complications during pregnancy and childbirth, such as bleeding, hypertension, prolonged and obstructed labour and infections, and lack of timely access to skilled care during and after birth.

11. The main risk factors associated with the leading causes of death in children aged between 1 month and 5 years include low birth weight, lack of breastfeeding, undernutrition, overcrowded conditions, indoor air pollution, unsafe drinking-water and food, lack of sanitation and poor hygiene practices. In some regions, HIV and malaria are also significant risk factors.

12. Undernutrition is estimated to be associated with 45 per cent of child deaths worldwide.[5] Undernutrition is also strongly correlated with vulnerability to infections and to delayed physical and mental development.

13. Many of the leading causes of mortality among children are also the primary causes of morbidity. Coughing, diarrhoea and fever are the commonest reasons for children to attend health services, and severe pneumonia, diarrhoea and malaria are the commonest causes of severe illness requiring hospital treatment. Other infections, disability arising from congenital malformations or pre-term birth, and nutritional deficiencies also contribute to child morbidity globally.

14. A high burden of child morbidity is attributable to violence against children, including physical, sexual and psychological violence, which exists in every country and occurs in various settings, including the family, institutions and the community.[7]

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[5] United Nations Inter-agency Group for Child Mortality Estimation., 2012.

[6] WHO, Global Health Observatory.

[7] A/61/299; A/HRC/22/31.

15. The life-course approach to health recognizes the continuum from birth through childhood, adolescence and adulthood. This approach reflects the principle that care given to children during their first five years of life, or even that given to their mothers prior to their birth, will affect their immediate well-being and will have an impact on their health and development in later years.[8]

16. A multi-faceted response, which also addresses the broader risk factors and determinants of child mortality and morbidity, is required.

17. The response must give sustained consideration to the needs of society's most disadvantaged and marginalized children and their families if improved and more equitable child health outcomes are to be achieved.[9]

III. A human rights-based approach

18. A human rights-based approach requires systematic attention to a range of human rights standards and principles. This approach is not only about achieving human rights goals and outcomes, but also about achieving them through a participatory, inclusive, non-discriminatory, transparent and responsive process.

19. A human rights-based approach to reducing child mortality and morbidity requires the identification of relevant duty-bearers and rights-holders, and building the capacity of the former to fulfil their obligations, and of the latter to claim their rights relevant to child health and survival. In this, States and State actors hold the principal obligation. In the case of young children, parents and other caregivers and health-care workers can simultaneously be considered both duty-bearers and rights-holders, who may benefit from capacity-building to fulfil their duties and claim respect for the rights of the children they represent.

20. International human rights law includes fundamental obligations by States to address under-5 mortality and morbidity as part of their work to ensure the child's right to the highest attainable standard of health and other related rights. It provides a legal framework for this work and a basis for accountability. A human rights-based approach requires systematic attention to human rights standards and principles in all aspects of policies and programmes.

21. A human rights-based approach to reducing child mortality and morbidity requires that States and other relevant stakeholders, including national human rights institutions and non-governmental organizations, take action at all levels to address the interlinked root causes of child mortality and morbidity. These root causes include poverty, malnutrition, gender inequality, harmful practices, violence, stigma, discrimination, unsafe households and environments, denial of the right to safe drinking water and sanitation, denial of the right to health, including lack of accessible, affordable and appropriate health services and medicines, late detection of childhood illnesses and denial of the right to education.

Human rights standards and principles

22. The Convention on the Rights of the Child provides a holistic framework for reducing child mortality and morbidity, emphasizing health outcomes, goods and services, and highlighting the need to tackle the underlying determinants of health.

[8] A/HRC/24/60.

[9] Ibid.

23. Article 6 of the Convention on the Rights of the Child highlights States parties' obligation to ensure the survival, growth and development of the child, including the physical, mental, moral, spiritual and social dimensions of their development. Article 24 recognizes the right of the child to the enjoyment of the highest attainable standard of health, explicitly requiring States parties to take appropriate measures to reduce infant and child mortality and to ensure the provision of necessary medical assistance and health care for all children.

24. Taking account of the indivisibility, interdependence and interrelatedness of all human rights, a human rights-based approach recognizes that fulfilment of the child's rights to health and survival depends on the realization of other related rights, including the rights to life, non-discrimination, an adequate standard of living, water and sanitation, food, education, birth registration and social security.

25. States are required to progressively realize those rights to the maximum extent of available resources and, where needed, within the framework of international cooperation.[10] While recognizing the principle of progressive realization and acknowledging constraints due to the limits of available resources, States have certain immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind and the obligation to take deliberate, concrete and targeted steps towards the full realization of this right.[11]

26. Child mortality and morbidity are also linked to women's rights and the ability of women to survive pregnancy and childbirth and to exercise autonomy over decisions relating to their reproductive lives and optimal infant feeding practices. Investment in women's health and education, and in the empowerment of the poorest and most marginalized population groups, including women, is vital to ensure an effective response to under-5 mortality.[12] The present technical guidance on a human rights-based approach to reducing preventable maternal morbidity and mortality can help guide work in this area.[13]

27. A human rights-based approach requires that States focus efforts to reduce child mortality and morbidity on marginalized children and those in under-served areas, and take all appropriate measures to ensure equality and protect children against discrimination. Discrimination, in law and in practice, is an important factor underlying much preventable child mortality and morbidity, with the most marginalized groups bearing a disproportionate burden of mortality and morbidity.[14] Discrimination is proscribed on the grounds of a child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.[15] Disproportionate vulnerability and ill health of certain groups of children can also exist beyond the proscribed grounds for discrimination.[16] The collection, analysis, dissemination and use of disaggregated data is a precondition for revealing where discrimination is occurring, which groups of children are not realizing their rights to health and survival and how remedial action might be taken.

28. Human rights provide a legal imperative for participation: in order to fulfil their human rights obligations, States must ensure stakeholder participation in priority-setting, in

[10] Convention on the Rights of the Child, art. 4; CRC/C/GC/15, paras. 71-72.

[11] Convention on the Rights of the Child, art. 2; E/C.12/2000/4.

[12] A/HRC/24/60.

[13] A/HRC/21/22 and Corr .1 and 2.

[14] M. Chopra and others, "Ending of preventable deaths from pneumonia and diarrhoea: an achievable goal", in *The Lancet*, Vol. 3, Issue 9876, 27 April 2013.

[15] Convention on the Rights of the Child, art. 2.

[16] A/HRC/22/31 and Corr. l.

policy/programme design, implementation, monitoring and evaluation, and in accountability mechanisms. This includes ensuring that institutional mechanisms exist that enable people to participate; ensuring that all segments of the population, including the most marginalized, can participate; and making available functional independent accountability mechanisms in relation to participation.

29. Participation requires that States create an enabling environment for citizen engagement and develop capacity to ensure that duty-bearers can fulfil their obligations and that rights-holders have the knowledge that allows them to claim their rights. Participation should be viewed as fostering critical awareness, and decision-making as the basis for active citizenship.[17] In the case of young children, such capacity-building may be targeted towards their caregivers.

30. Participation in the context of under-5 mortality and morbidity means ensuring that children's parents, or other representatives, can access all relevant and necessary information to ensure an informed opinion about the child's health status and potential interventions, and participate meaningfully in the decision-making processes which affect their children's survival and health.

31. The best interests of the child should be assessed and taken as a primary consideration in all actions affecting children, including actions concerning their health, and should guide decisions on issues ranging from individual treatment options to policy and regulatory frameworks. This requires that States place children's interests at the centre of all decisions affecting their health and survival, including decisions on the allocation of resources and on the development and implementation of policies and interventions that affect the underlying determinants of health.

32. Ensuring accountability is at the core of actions to address under-5 mortality and morbidity. Accountability requires multiple forms of monitoring, review, oversight and redress – administrative, social, political and legal. States have the obligation to ensure that relevant government authorities and service providers are accountable for maintaining the highest possible standards of children's health and health care. This means, for instance, ensuring that health service users are able to report essential medicine stock-outs in addition to ensuring that there procedures for investigating preventable deaths. States have an obligation to ensure that functional, accessible accountability mechanisms exist such that all duty-bearers can be held to account and that both the individual and the structural nature of any children's rights violations and harm caused by discrimination in regard to children's health-related rights can be addressed.[18]

33. A human rights-based approach to health requires States to ensure the availability, accessibility, affordability, acceptability and quality of facilities, goods and services related to health, as well as to address its underlying determinants, such as poverty, poor education and lack of access to other social services.[19] A well-developed and accessible health system characterized by attention to all the principles of a human rights-based approach, through which children and caregivers have access to health information, services and commodities, is critical. Similarly, collaboration across government sectors is required to address the underlying determinants of health.

34. The State bears the primary human rights obligation in relation to child health and survival and also has an obligation to ensure that non-State actors, including individuals, do

[17] United Nations Population Fund and Harvard School of Public Health, A Human Rights-based Approach to Programming: Practical Implementation Manual and Training Materials, 2010.

[18] E/C.12/GC/20, para. 40.

[19] E/C.12/2000/4.

not jeopardize the enjoyment by any child of his or her health and human rights. Alongside its obligations to ensure children's non-discriminatory access to high-quality health and related services that are socially and culturally acceptable, the State has a crucial role to play, and is obliged under human rights law, to sensitize the population about appropriate care-seeking behaviours for child health.[20]

35. In a recent report to the Human Rights Council a number of essential steps for effectively addressing under-5 mortality using a human rights-based approach were highlighted.[21] They include: ensuring a supportive legal and policy environment; increasing access to preventive health interventions, services and life-saving drugs; expanding access to services for the integrated management of childhood illnesses at the community level and elsewhere; and establishing accessible, transparent and effective mechanisms of monitoring and accountability.

IV. Operational guidance

36. Applying a human rights-based approach to reducing child mortality and morbidity means systematically incorporating attention to all relevant rights, standards and principles into national measures aimed at improving child health and survival. This begins with an assessment of relevant legislative measures, governance and coordination mechanisms, planning, budgeting, implementation, monitoring and evaluation efforts, mechanisms for remedy and redress and international cooperation to determine the extent to which existing measures, mechanisms and processes are fully compliant with recognized human rights standards and principles and where gaps and barriers remain that must be addressed. This should build on existing efforts with additional attention to human rights standards and principles as required.

37. Rights-based efforts to reduce child mortality and morbidity should adopt a life course approach. They should be situated within a continuum of care that pays due attention to the health and rights of women before, during and after pregnancy.[22]

38. Reliable data on priority health problems, including new and neglected causes of mortality and morbidity, and key determinants of children's health, enable States and other duty-bearers to target efforts to address child mortality and morbidity. Governments and other stakeholders should collect such data through routine health information systems as well as other surveys and research, and ensure that they include quantitative, qualitative and policy data.

39. A human rights-based approach requires that those data be disaggregated by age, sex, location and other relevant categories in order to identify groups that may be marginalized or discriminated against and to direct additional efforts and resources to ensuring that any inequalities are addressed.

40. Data should be analysed, disseminated and used to inform national and subnational laws, policies, budgets, programmes and services relevant to child health and survival.

41. In the subsections below, illustrative examples are provided of State actions required under a human rights-based approach to reducing child mortality and morbidity.

[20] Convention on the Rights of the Child, art. 27.
[21] A/HRC/24/60.
[22] A/HRC/21/22 and Corr. 1 and 2.

A. Legislative measures

42. Article 4 of the Convention on the Rights of the Child stipulates the requirement for States parties to take all necessary legislative measures for the implementation of the rights recognized in the Convention. This includes incorporating into national legal frameworks all international human rights commitments, ensuring that services and medications are available at appropriate levels of the health system to maximize safe uptake, ensuring non-discrimination in access to health-related information and services, and removing impediments to realizing the child's rights to health and survival.

43. The Committee on the Rights of the Child has determined that "a comprehensive review of all domestic legislation and related administrative guidance to ensure full compliance with the Convention is an obligation" and that States parties "need to ensure, by all appropriate means, that the provisions of the Convention are given legal effect within their domestic legal systems".[23] This should begin with an assessment of the existing legislative framework and structures for any potential impediment to, or discriminatory effect on, reducing child mortality and morbidity. Alongside an analysis of data on priority child health issues, such an assessment can highlight where current legislative measures are sufficient, where amendments or repeal may be needed and where legislative gaps exist that need to be filled.

44. States are required to enact national laws that:

(a) Incorporate international human rights commitments relevant to child health and survival;

(b) Place a statutory obligation on the State to provide the services, programmes, human resources and infrastructure needed to realize children's rights relating to health and survival, including those considered core obligations;[24]

(c) Recognize children as rights-holders and define the scope of their rights relating to health and survival based on international human rights obligations;

(d) Clarify what services children, pregnant women and parents are entitled to claim, and disseminate that information;

(e) Provide a statutory entitlement to essential, child-sensitive, high-quality health and related services for pregnant women and children under 5, including birth registration and other social services, irrespective of their ability to pay;

(f) Regulate public and private services and medications relating to child health to ensure that they cause no harm and are of good quality;

(g) Enable public participation and dialogue in legislative processes by ensuring functional national and subnational political processes and public forums;

(h) Provide a framework for access to effective, child-friendly legal remedies, both judicial and non-judicial, in the case of human rights violations in relation to child health and survival, and ensure that statutes of limitation are not unduly restrictive.[25]

[23] CRC/GC/2003/5, paras. 18-19.

[24] E/C.12/2000/4, paras. 43-44; CRC/C/GC/15, para. 73.

[25] General Assembly resolution 60/147, annex, para. 7.

B. Governance and coordination

45. Governance of child health means ensuring that the appropriate systems and coordination mechanisms are in place to facilitate the full realization of all child health-related rights and to provide avenues for remedy and redress where obligations are not fulfilled. This includes ensuring collaboration, coordination and dialogue between government ministries, local governments, service providers and communities, and supporting systematic monitoring and follow-up action to ensure that children's health-related rights are realized.[26]

46. Strong governance and coordination mechanisms are particularly critical in the context of a human rights-based approach to child mortality and morbidity given the need for attention to the wide range of actors involved, including health and other sectors within government, the private sector, families, communities, civil society and other stakeholders. Building on existing systems, strengthening them and adapting them as appropriate can facilitate the realization of child health-related rights and reduce child mortality and morbidity.

47. Decisions about allocations to different levels of services and geographical areas should reflect patterns of mortality and morbidity, the core elements of the primary health care approach and due attention to disadvantaged groups. While decentralization or delegation may be required to meet the particular needs of localities, sectors or federal systems, this does not reduce the direct responsibility of the central or national government to fulfil its obligations to all children within its jurisdiction. Similarly, the State remains fully accountable, regardless of the level of involvement of the private sector.

48. States are required to:

(a) Ratify and implement international human rights instruments and their related optional protocols relevant to under-5 mortality and morbidity, and ensure the inclusion of information on efforts made to reduce under-5 mortality and morbidity in periodic reports to human rights mechanisms;

(b) Adopt and enforce appropriate laws and regulations;

(c) Ensure that appropriate structures, processes and resources are made available to translate laws and policies relating to child health and survival into practice, including institutional reform and capacity-building for duty-bearers to enable them to understand and meet their obligations as required;

(d) Identify and remove obstacles to transparency, coordination, partnership and accountability in the provision of services affecting child health and survival;

(e) Establish and use a comprehensive and cohesive national coordinating framework on children's health, situated within child welfare and protection systems as well as within the continuum of care for reproductive, maternal, neonatal and child health, and built upon human rights standards and principles. This will facilitate cooperation between government ministries and different levels of government, as well as interaction with civil society, including parents and other caregivers;

[26] UNICEF Cambodia, "Local governance for child rights".

(f) Engage all sectors of society in reducing child mortality and morbidity. This should include:

(i) The creation of conditions conducive to the continual growth, development and sustainability of relevant civil society organizations;

(ii) Active facilitation of civil society involvement in the development, implementation, monitoring and evaluation of children's health policies and services;

(iii) The provision of appropriate financial support, or assistance in obtaining financial support, to relevant civil society organizations;

(iv) Capacity-building of rights-holders to enable them to understand their entitlements in relation to child health and survival and engage productively with service providers in securing those entitlements;

(g) Clarify the roles and responsibilities of all duty-bearers with regard to child health and survival;

(h) Ensure that all sectors working to address child mortality and morbidity fulfil their human rights-related responsibilities. This includes ensuring non-discrimination in service delivery, transparency in budgeting, and functional mechanisms for accountability;

(i) Identify and prioritize action to benefit children from marginalized groups and children who are at risk of any form of violence or discrimination.

C. Planning

49. Guaranteeing the child's rights to health and survival implies an obligation to have a long-term national plan to address child mortality and morbidity based on evidence and the promotion and protection of human rights. The first step in all planning processes should be a situation analysis, not only to identify priority child health issues and their underlying determinants but also to map existing plans, services and capacities for addressing them. This should identify duty-bearers and include an assessment of their capacity to fulfil their human rights-related obligations in this regard. Situation analysis data should be disaggregated to enable groups of children who are marginalized and/or have particularly poor health indicators to be identified.

50. Based on the situation analysis and building on existing national and subnational strategies and plans, a strategy or plan should be developed. Benchmarks and targets which focus on child survival and development should be established to demonstrate the planned progressive realization of child health-related rights.

51. States are required to:

(a) Ensure that the national plan is informed by appropriately disaggregated data and incorporates attention to groups of children who are the most marginalized, discriminated against and/or have the poorest health indicators. Where disaggregated data are unavailable, plans should include an approach to their timely collection;

(b) Involve a wide range of stakeholders in planning processes, including State and non-State actors;

(c) Include child health and survival in other sectoral policies, highlighting the links between children's health and survival and the underlying determinants of health;

(d) Assess current institutional capacity to fulfil duty-bearers' roles and responsibilities for child health and provide adequate resources, including capacity-building, to ensure that those roles can be fulfilled;

(e) Ensure that all goods, services and information relevant to child health, whether provided through facilities or community-based interventions, are available, accessible and acceptable to all, as well as being of good quality;

(f) Ensure an appropriate and equitable distribution of resources, including financial resources, health services, goods and facilities and an adequately trained health workforce, to address child mortality and morbidity, with adequate attention to marginalized populations;

(g) Establish benchmarks and targets, budgeted action plans and operational strategies to reduce child mortality and morbidity within the time frame of the plan;

(h) Develop a framework for monitoring and evaluating policies, programmes and services, and promoting accountability for child mortality and morbidity;

(i) Make accessible the national plan and any accompanying plans of action and budgets to all rights-holders and duty-bearers.

D. Budgeting

52. States have an obligation to take steps to address child mortality and morbidity to the maximum of their available resources. This includes demonstrating their commitment to the progressive fulfilment of all their obligations in relation to child mortality and morbidity and prioritizing them even in the context of political or economic crises or emergency situations. This requires sustainable financing for children's health and related policies, programmes and services. International funding assistance is of crucial importance but should not replace governmental funding to address child mortality and morbidity and does not relieve States of their obligation to devote the maximum available resources to that area.

53. If the overall State budget increases, the budget to address child mortality and morbidity should increase. Conversely, in the face of overall budget reductions, the budget for addressing child mortality and morbidity should not be reduced unless the State can demonstrate that it has taken all reasonable measures to avoid such a reduction. Policy-makers are obliged to avoid decisions that might reduce the enjoyment of human rights by any group considered marginalized or discriminated against.

54. All activities should be fully costed, financed and made visible within national and subnational budgets. Budget planning, monitoring and evaluation processes relating to child health and survival should include the participation of citizens, civil society and health service providers.

55. Child health budgets should be transparent and used to ensure government accountability for child health, including the realization of child health-related rights. Transparency and simplification of processes relating to child health budgeting and expenditure may be required, to promote civil society involvement in planning, monitoring and evaluating work in those areas. Where budgets and allocations are insufficient to fulfil governmental obligations with regard to the child's right to health, civil society has an important role to play.

56. States are required to:

(a) Make investment in child health and survival visible in the State budget through detailed compilation of resources allocated to them and expended;

(b) Meet the WHO-recommended minimum health expenditure per capita[27] and prioritize child health in budgetary allocations;

(c) Increase the budget and expenditure to address child mortality and morbidity, and their underlying determinants, over time, using interim benchmarks and targets to demonstrate progress, in line with the principle of progressive realization;

(d) Focus investment on the populations of children that are most marginalized and discriminated against;

(e) Reduce reliance on direct, out-of-pocket payments, increase the level and share of revenues channelled through prepaid and pooled mechanisms, and use the pooled funds to cover health-care costs for economically disadvantaged children;

(f) Implement rights-based budget planning, monitoring and analysis, as well as impact assessments of how investments, particularly in the health sector, may improve child health and survival outcomes;

(g) Identify insufficiencies and bottlenecks in child health budgeting and the disbursement of funds and take appropriate remedial action as required;

(h) Ensure sufficient transparency in budgets relating to child health to allow effective and participatory tracking of the flow of resources, including budgeting, allocation and expenditure, and its timeliness, from the national ministry of health through all levels down to health facilities.

E. Implementation

57. Ensuring access to interventions, services and medications for child health requires action across the health sector, and also beyond it to encompass efforts in other sectors to address the underlying and structural determinants of child mortality and morbidity. Multisectoral action is required that fully conforms with international human rights standards and principles with regard to both its desired outcomes and its implementation processes.

58. States have an obligation to ensure for all children and caregivers the availability, accessibility, acceptability and quality of all facilities, goods and services relating to child health and survival, including services outside the health sector. Special attention may be required to reach the most marginalized child populations, in order to fulfil the obligation of immediate application of the principles of equality and non-discrimination.

59. States are required to:

(a) Build the capacity of duty-bearers to fulfil their obligations and of children, parents and other caregivers to understand and claim their child health- and survival-related rights;

(b) Ensure that health workers are adequately trained in child health and child rights, supervised and mentored;

(c) Provide access to essential interventions for addressing child mortality and morbidity[28] as well as other interventions outside the health sector to address underlying determinants;

[27] WHO. "Spending on health: A global overview", Factsheet No. 319, April 2012.

(d) Provide access to essential medicines for addressing child mortality and morbidity included in the WHO list of essential medicines for children;[29]

(e) Adopt evidence-based interventions to support good parenting, including parenting skills education, support group and family counselling, especially for families experiencing children's health and other social challenges;[30]

(f) Ensure functional systems for the prevention, identification and reporting of abuse, neglect or negligent treatment, maltreatment or exploitation of children while in the care of parents or other caretakers;[31]

(g) Ensure the participation of affected populations and other stakeholders in implementing efforts to address child mortality and morbidity. This might include, for example, consulting parents and caregivers on their priorities for addressing child mortality and morbidity, or involving community members in health facility management committees;

(h) Ensure, including through the analysis of disaggregated data, that the implementation of policies, programmes and services does not discriminate against any segment of the population and that, where necessary, additional efforts are made to reach populations of children who are marginalized or discriminated against;

(i) Reduce reliance on out-of-pocket payments for health services by providing social protection or sharing financial risks across the population, which promotes access to services by the most marginalized populations.

F. Monitoring and evaluation

60. Monitoring and evaluation of data relating to child mortality and morbidity, collected regularly and rigorously, are required to track fulfilment of relevant human rights as well as to inform policies, programmes and services. Well-functioning health information and surveillance systems should ensure that data are reliable, transparent and consistent, while protecting the right to privacy of children and their families. Data should be disaggregated to reveal which groups of children are being left behind and should be regularly used to track progress and direct action.

61. National accountability mechanisms should monitor, review and recommend remedial action based on their findings. Monitoring means providing data on the health status of children, the quality of children's health services, and how much is spent, where, on what and on whom. This should include both routine monitoring and periodic, in-depth evaluations. Reviewing means analysing the data and consulting children, families, other caregivers and civil society to determine whether children's health has improved and whether governments and other actors have fulfilled their commitments. Acting means using evidence emerging from those processes to repeat and expand what is working and to remedy and reform what is not.[32]

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[28] The Partnership for Maternal, Newborn and Child Health, *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health*, (Geneva,2011).

[29] WHO model list of essential medicines for children, available from www.who.int/medicines/publications/essentialmedicines/en/.

[30] CRC/C/GC/15, para. 67.

[31] Convention on the Rights of the Child, art.19; CRC/C/GC/13, paras. 47-49.

[32] CRC/C/GC/15, para. 118.

62. Existing monitoring, evaluation and accountability processes and mechanisms should be assessed to determine the extent to which those functions can be fulfilled to help ensure child health and survival and where they may need to be strengthened. The generation and use of timely and accurate information relating to all factors affecting child mortality and morbidity are key to improving child health, informing an appropriate and effective response and ensuring the accountability of duty-bearers.

63. States are required to:

(a) Regularly review their health information system, including vital registration and childhood disease surveillance, with a view to its improvement;

(b) Create a well-structured and appropriately-disaggregated set of quantitative and qualitative indicators that encompasses key recommended child health indicators within and beyond the health sector, with a view to measuring changes in child health and survival, tracking progress towards established targets and addressing any discrimination;

(c) Monitor and evaluate the effects of the national legal and policy framework on child mortality and morbidity;

(d) Monitor budget allocations and expenditure for child health and other factors affecting child mortality and morbidity;

(e) Ensure the existence of quality assurance systems for education and training, including accreditation and certification for both private and public health workers, that meet nationally and internationally agreed standards;

(f) Monitor and evaluate non-State actors' fulfilment of their human rights responsibilities relevant to child health and survival, including that of private sector providers of health and ancillary services;

(g) Include civil society and other community members in the collection and analysis of monitoring and evaluation data relating to child health, as well as in making decisions arising from analysis of those data;

(h) Conduct regular reviews of child deaths in order that lessons may be learned at all levels of health and other systems, as a way to inform actions to prevent future child deaths;

(i) Monitor the use of mechanisms for reporting, remedy and redress in the case of violations of human rights relating to child mortality and morbidity and ensure their functionality;

(j) Disseminate the findings of child health monitoring and evaluation efforts and use the data to adapt and improve policies, programmes and services relating to child mortality and morbidity;

(k) Establish transparent accountability processes and mechanisms by setting performance targets, collecting information about action taken to meet those targets, making public judgements about the adequacy of such actions and imposing sanctions for unsatisfactory performance.

G. Remedies and redress

64. For rights to have meaning, effective remedies must be available to redress violations. Effective mechanisms for remedy and redress can promote the implementation of existing laws, policies and programmes, inform the reform of laws, policies and budgets that do not adequately protect children's rights, challenge barriers to access to child health care, and provide redress for violations of child health-related rights. Judicial, medical and

other personnel should have adequate capacity to understand and respect the evolving maturity of the child and the child's right to be heard.

65. Functional accountability mechanisms that are enforceable not only through the courts but also through quasi- and non-judicial mechanisms such as national human rights institutions, children's ombudspersons and subnational social accountability and complaints mechanisms are a critical element of a human rights-based approach to reducing child mortality and morbidity.

66. An audit of existing remedy and redress mechanisms can help to identify areas that require strengthening.

67. States are required to:

(a) Provide, in law, policy and budgets, for a range of effective monitoring, claims and redress mechanisms available and accessible to children and their caregivers. They should include the provision of child-friendly information, advice, advocacy and access to the courts with necessary legal and other assistance;[33]

(b) Ensure and facilitate access to courts, as well as to quasi- and non-judicial accountability mechanisms, for parents and caregivers;

(c) Ensure community participation in determining appropriate mechanisms for accountability, including remedy and redress, relevant to child health and survival;

(d) Raise awareness about the applicability of claims relating to child health-related rights among lawyers, judges, parents and caregivers through training, education and, where necessary, support to families;

(e) Ensure that where rights are found to have been breached there is appropriate reparation, including, where needed, compensation and measures to promote physical and psychological recovery, rehabilitation and reintegration;[34]

(f) Identify and remove any barriers to accessing mechanisms for reporting, remedying and redressing human rights violations in relation to child mortality and morbidity;

(g) Ensure that independent accountability mechanisms can be used to hold in-country stakeholders as well as international cooperation partners to account.

H. International cooperation

68. States have an obligation to promote and encourage international cooperation with a view to achieving progressively the full realization of the child's right to health.[35] International cooperation efforts should be rights-based in terms of the outcomes they seek to achieve as well as their own processes of design, implementation, monitoring and evaluation. Coordination among different States giving and receiving cooperation assistance is required to ensure the complementarity of efforts to address child mortality and morbidity as well as their consonance with local priorities.

69. States and development partners are required to pay particular attention to children's health priorities in resource-limited settings, in accordance with the Convention on the Rights of the Child, the Iinternational Covenant on Economic, Social and Cultural Rights

[33] Ibid.
[34] Ibid.
[35] Convention on the Rights of the Child, art 24, para. 4.

and other relevant principles and guidelines.[36] Non-State development partners such as foundations, the private sector, international financial institutions and non-governmental organizations, also have responsibilities to ensure that child rights relating to health and survival are not violated through their actions.[37]

70. States are required to:

(a) Direct international cooperation assistance to support and strengthen State-led health systems and national plans to address child mortality and morbidity;

(b) Adopt a human rights-based approach to international cooperation for reducing child mortality and morbidity by ensuring attention to all relevant human rights standards and principles, for example by ensuring that priorities are set through participatory processes, that there is a focus on the most excluded and discriminated against, and that mechanisms for international accountability are in place;

(c) Ensure that all international cooperation supports laws, policies, programmes and services designed, implemented, monitored and evaluated using a human rights-based approach to reducing child mortality and morbidity;

(d) Seek to ensure predictable, harmonized and transparent international cooperation to support State responses to child mortality and morbidity;

(e) Strengthen their international commitment, cooperation and mutual assistance with the objective of reducing child mortality and morbidity, including through the sharing of good practices, research, policies, monitoring and capacity-building;

(f) Direct their international cooperation assistance to supporting the creation of an environment in which all members of society can discharge their responsibilities with regard to child-health related human rights.[38] This may include, for example, supporting social protection policies so that parents and caregivers are able to fulfil their responsibilities towards their children;

(g) Regulate, in line with relevant principles,[39] private actors over which they exercise control, such as pharmaceutical companies, commodities and device manufacturers, producers and marketers of breastmilk substitutes and other companies that affect efforts to address child mortality and morbidity overseas, in order to prevent violations of child health-related rights and ensure accountability, including remedy and redress, if violations occur;[40]

(h) Minimize the impact of economic sanctions on child health and survival.[41]

V. Illustrative example: addressing neonatal mortality

71. The example provided below seeks to illustrate a human rights-based approach to reducing neonatal mortality and demonstrates the practical value of this approach.

72. It covers different levels of intervention relevant to the prevention of neonatal mortality: laws and policies, access to health information and services and community-

[36] The principles of the Paris Declaration on Aid Effectiveness; and the principles of the Accra Agenda for Action.

[37] Guiding Principles on Business and Human Rights (A/HRC/17/31).

[38] E/C.12/2000/4.

[39] A/HRC/17/31; Children's Rights and Business Principles.

[40] E/C.12/2000/4; CRC/GC/16.

[41] E/C.12/1997/8.

based action. In addition, it encompasses systematic attention to each of the key principles of a human rights-based approach and selected elements of the operational guidance.

73. Neonatal mortality - deaths within the first 28 days of life - accounts for approximately 43 per cent of all child deaths.[42] Up to two thirds of those deaths could be prevented if known effective health measures were provided at birth and during the first week of life.[43]

74. Tackling neonatal mortality includes attention to the care of pregnant women, skilled attendance at delivery, and management of neonatal sepsis. However, low education levels, lack of access to clean water and adequate sanitation, insufficient access to health services (including emergency care at delivery), gender discrimination and a lack of empowerment prevent women from seeking health care and making the best choices for themselves and their children's health, resulting in delays and poorer health outcomes. A human rights-based approach to addressing neonatal mortality encompasses attention to all of these dimensions of women's and neonatal health care, including the underlying determinants of neonatal mortality.

75. Attention to the issues raised by the child's rights to health and survival and other relevant human rights, should be incorporated throughout policy and budget planning processes. These processes require identifying the resource needs for implementation and prioritizing actions through transparent mechanisms of accountability.

Legal and policy environment

76. A first step is to ratify international treaties relevant to neonatal mortality and incorporate them into national laws and policies.

77. Adopting and enforcing laws and policies that promote access to high-quality maternal and newborn care in both the public and private sectors is a key component of a human rights-based approach to preventing neonatal mortality. This encompasses laws and policies for: ensuring universal access by women and children to health-care services, birth registration and social services; non-discrimination; notification of maternal and perinatal deaths; context-specific approaches to HIV and infant feeding; and implementing and monitoring the International Code of Marketing of Breast-milk Substitutes.

78. In addition, workplace policies are important to support women during pregnancy and in the postnatal period by protecting pregnant women from physically demanding work and supporting breastfeeding in the workplace.[44]

Health services

79. Given the critical importance of health services to neonatal health in the immediate postnatal period, attention to the availability, accessibility, acceptability and quality of facilities, goods and services is required.

80. It is important that the availability of life-saving interventions and commodities be secured in all health facilities, including those in remote areas. Attention to non-discrimination ensures that actions to address neonatal mortality are sufficiently targeted to marginalized communities to eliminate inequalities.

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[42] WHO, Global Health Observatory.

[43] WHO. Newborns: reducing mortality factsheet.2012.

[44] ILO.Maternity Protection Convention, 2000 (No. 183).

81. Access to early postnatal care for mothers and newborns within two days of birth has a major impact on newborn health and can be enhanced through the elimination of user fees for maternal and neonatal health services that might pose a barrier to service uptake.

82. The availability of skilled health workers who are motivated, adequately equipped and appropriately distributed is critical to ensuring access to services. Providing extra care to babies with low birth weight is particularly important to reduce newborn mortality, and health personnel need to be given the capacity and a clear mandate to support those babies and their mothers. Ensuring that midwifery curricula meet global standards and that students acquire the necessary competencies to deliver good-quality services with confidence can help ensure an adequately skilled health workforce.

83. Appropriate care during labour, birth and in the immediate postnatal period can prevent the onset of complications or enable their early detection and prompt management. Ensuring the acceptability of maternal and neonatal health services requires, for example, ensuring that women are treated with dignity and respect, that pain management is provided for mothers and newborns, and that there is no unnecessary separation of mothers and newborns.

84. Ensuring the quality of maternal and neonatal services for all women and infants without discrimination may increase their uptake and have a positive impact on neonatal mortality.

85. Alongside the expansion of service delivery, a human rights-based approach requires addressing the underlying legal, policy and practical reasons, for example poverty, low levels of education, gender inequality, disability and discrimination, why access to neonatal health services remains constrained for some populations.

86. The principles of equality and non-discrimination demand attention to why neonatal mortality remains a problem and which groups of infants are most affected. They require that national policies and programmes prioritize improving access for the most marginalized populations. Those groups will vary according to the context, which again highlights the need for appropriately disaggregated data as a tool for identifying groups that may require special attention.

87. To ensure accountability at the health facility level, feedback mechanisms should be in place for health workers and clients to identify any shortcomings in service provision, such as drug stock-outs or poor quality of care, that managers should review and take appropriate action on in a timely fashion.

Community-level interventions

88. Involving communities in child health-related activities can reduce neonatal mortality and help ensure that interventions are appropriate and effective.[45] A recent review found benefits for maternal and child health outcomes from attention to participation, particularly in combination with additional human rights principles.[46]

89. Community health committees, whose membership combines local citizens and community health workers, are an example of a mechanism through which community participation can help improve neonatal health outcomes by sharing responsibility for ensuring that services maintain a certain standard of performance. The human rights

[45] M. Rosato and others, "Community participation: lessons for maternal, newborn, and child health", in *The Lancet*, Vol. 372, Issue 9642, 13 September 2008.

[46] F. Bustreo and others, "Women's and children's health", footnote 4.

principles of participation, equality and non-discrimination require ensuring that various groups of women are included.

90. Ensuring the participation of marginalized groups in community health committees requires reaching, and supporting the engagement of, those who are often not reached, such as remote populations, women at risk of adverse pregnancy outcomes, people with low capacity to engage in health and development processes and people who have little experience of articulating their needs and priorities.

91. Strategies should empower committee members to articulate their expectations towards the State and other duty-bearers to take charge of their own development and to facilitate collaboration with others in implementing interventions.[47]

92. Situated within the community, committee members are ideally placed to advise on where, when and how interventions to address neonatal mortality can be delivered to ensure their availability, accessibility and acceptability to the whole community, especially the most marginalized.[48] In this way, in addition to improving access to information and services, community participation in planning service delivery can also contribute to addressing inequalities in neonatal outcomes.

93. An independent accountability mechanism with accessible complaints mechanisms will also be important for promoting social accountability, by ensuring that community members can monitor local health service delivery and the committee's activities.

94. This example of a human rights-based approach to reducing neonatal mortality highlights that, beyond the legal imperative for attention to human rights, this approach can lead to better health outcomes by ensuring systematic attention to the legal and policy environment, equality and non-discrimination, the participation of affected populations, the best interests of the child, accountability and the availability, accessibility, acceptability and quality of child health facilities, goods and services.

VI. Moving forward

95. **To ensure that all efforts to reduce child mortality and morbidity fully conform to recognized international human rights standards and principles, the Office of the United Nations High Commissioner for Human Rights (OHCHR) strongly encourages the implementation of the present technical guidance at the national and subnational levels.**

96. **States should disseminate the technical guidance to all relevant government sectors and other stakeholders, and ensure its systematic application in the development, implementation and review of laws, policies, budgets and programmes related to child to health and survival. States are also encouraged to generate and disseminate examples of good practice of implementation of a human rights-based approach to reducing child mortality and morbidity.**

97. **The technical guidance should be applied within the framework of the broader recommendations made by the High Commissioner for Human Rights, the WHO and the Independent Expert Review Group on Monitoring and Accountability for Women's and Children's Health on strengthening human rights and accountability frameworks to achieve better health and accountability for women and children. To**

[47] OHCHR, *Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation*, 2006.

[48] A/HRC/21/22 and Corr. 1 and 2.

that end, relevant United Nations entities, as well as other relevant stakeholders, should provide necessary technical assistance to States in the application of the technical guidance, including through the development and dissemination of tools for its operationalization at all relevant stages of national planning and action cycles for child health and survival.

98. **States and other relevant stakeholders are strongly encouraged to take into account the technical guidance in their deliberations on the post-2015 development agenda, as well as in the implementation and monitoring of the new development goals.**

99. **OHCHR invites human rights mechanisms to pay particular attention to State efforts to reduce under-5 mortality and morbidity.**